STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005078	A. BUILDING: _____ B. WING _____	03/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT ANDERSON REGIONAL HOSPITAL INC	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00121194 Unsubstantiated; lack of sufficient evidence. Survey Date: 3-13-13 Facility Number: 005078 Surveyor: Brian Montgomery, RN Public Health Nurse Surveyor St Vincent Anderson Regional Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules. QA: claughlin 04/03/13	S 000		